



**SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU**

**HOME AND COMMUNITY BASED WAIVER
Policy Manual**

Section: SERVICES

Subject: Residential Habilitation

References: ARM: 37.40.1435

DEFINITION

The Residential Habilitation (RH) services are divided into the following 4 categories:

1. Adult Residential (AR) – service provided in an Adult Foster Home (AFH) or an assisted Living Facility (ALF) - T2031
2. Specialized Adult Residential Care Facility – T2016
3. Group Home – T2016

Case management teams (CMT) have a fixed number of slots for this service.

Under special circumstances and with prior approval from Central Officer, Residential Habilitation could be provided to a child in a foster care setting.

**COVERED
SERVICES**

Residential habilitation is a bundled service which includes, at a minimum, personal care, well-being, health and safety needs of the members are met at all times.

REQUIREMENTS

The Department of Public Health and Human Services (DPHHS) must license adult foster homes, group homes and assisted living facilities. HCBS members in these facilities cannot have needs, which are beyond the scope of the provider's license. CMT records must include the signed resident agreement for member in assisted living facilities.

ADULT RESIDENTIAL

Adult Foster Homes

According to the rules governing these facilities, residents should require only light personal care and cannot have more than 30 consecutive days or skilled nursing visits, not to exceed 2 hours a day. The latter does not include setting up medications even if a nurse performs this task. It may be acceptable for an individual to receive nursing services in excess of the limit if they are not consecutive **and** if the resident's condition, which requires the nursing, is not chronic. If an individual cannot self-administer medications, they should not be in an adult foster home.

Assisted Living Facilities

A Bed - This type of bed is limited to skilled nursing care or other skilled services related to temporary, short-term acute illness, which may not exceed 30 consecutive days for one episode or more than 120 days total in one year. This means that if the resident or the resident's family contracts for the nursing, the latter is not included in the limit, i.e., third party providers not contracting with the facility can provide nursing for longer than 30 consecutive days.

B Bed – A resident of a B bed can receive any skilled services that would be available in a nursing home as long as the facility meets all the conditions outlined in the licensure rule.

C Facility – A category "C" facility refers to an assisted living that has a secure distinct part or locked unit that is designated for the exclusive use of residents with severe cognitive impairment. Severe cognitive impairment means the loss of intellectual functions, such as thinking, remembering and reasoning, of sufficient severity to interfere with a person's daily functioning. Such a person is incapable of recognizing danger, self-evacuating, summoning assistance, expressing need and/or making basic care decisions.

SPECIALIZED
ADULT
RESIDENTIAL

Specialized Adult Residential is provided in an assisted living facility that specializes in the care of individuals with brain injuries or other severe disabilities. It is a bundled service that, in addition to the covered services listed above, include social and recreational activities at least twice a week,

transportation, money management, medical escort and 24 hour on-site awake staff to meet the needs of the residents and provide supervision for safety and security.

Specialized Adult Residential is a care category 3 (CC3) service and must be initially prior authorized by the Department. Refer to HCBS 403.

GROUP HOMES

These homes are available to members with severe disabilities. The Specialized Adult Residential requirements also pertain to Group Homes, including the need for prior authorization by the Department.

All Group Homes and Specialized Adult Residential care facilities must be licensed by the State of Montana. The homes must be wheel chair accessible, have an accessible bathroom/shower and provide 24-hour awake staff. Staff must have 8 hours of documented brain injury or disability specific training for staff. This training must be verified annually by the case management team.

RESIDENTIAL HABILIATION LIMITATIONS

Medicaid reimbursement for room and board is prohibited. The provider may not bill Medicaid for services on days the member is absent from the facility, unless retainer days (max of 30 days per year) have been approved by the CMT. Refer to HCBS 410. The provider may bill on date of admission and discharge from a hospital or nursing facility. If the member is transferring from one adult residential care setting to another, billing is not allowed by both facilities on the day of transfer. The admitting facility bills for this day. Members in any of the care settings under the Residential Habilitation service may not receive the following services under the HCBS program:

1. Personal Assistance (with the exception of social PCA or SATA that is beyond what is required to be provided by the facility)
2. Homemaking
3. Environmental modifications
4. Respite
5. Meals

Personal Emergency Response Systems (PERS) is a required component of an ALF, and should not be routinely reimbursed by waiver funds. However, if the CMT feels that the member's circumstances warrant the authorization of

a PERS, they must document the specific reasons prior to initiation of service.

These restrictions apply only when HCBS payment is being made for the residential habilitation service.

If a member chooses to leave a residential habilitation care setting without giving the required 30 day notice to the facility, HCBS reimbursement cannot be sued to pay the daily rate for the remaining days.

PAYMENT

Adult Residential Care Facility and Foster Home

Reimbursement for adult residential care facilities and foster homes is calculated using the SLTC-132. Refer to 899-9 for adult residential care calculation instructions. State supplement (HCBS 899-26) for assisted living facilities equals \$94.00 per month and for adult foster homes equals \$52.75 per month. Use these totals on the SLTC-132 even if the member is receiving less than the \$94.00 or \$52.75. Their state supplement amount is determined by Social Security taking into account their current income and it will equal the SSI amount plus \$94.00 (in an assisted living facility) or \$52.75 (in an adult foster home). Members in B or C category beds are not entitled to state supplement. Refer to 899-26 for more information on state supplement. See chart in 899-9, page 6 for current maximum daily rate.

Reimbursement for room and board is set by the Department as the current Medically Needy Income Level minus \$100.00. This room and board is for the standard room/apartment in the facility. Reimbursement for services covers only those services indicated on page 1 and those indicated on the rate calculation sheet. Items not reimbursable by Medicaid are the responsibility of the member and/or member's family (i.e., beautician/barber services). Supplementation to the rate by member or family is not allowable.

Specialized Adult Residential Care Facility and Group Home

Reimbursement for specialized adult residential care facilities and group homes is a fixed daily rate. See current fee schedule.

Aide and Attendance payments through the Veteran's Administration are not considered income for purposes of eligibility determination. However, the payments must be used to help meet the member's cost of care. Therefore, the income is used in the calculation of income applicable to cost of care. The Office of Public Assistance (OPA) will determine the amount the member is responsible to pay the

facility. Members receiving A & A service cannot use the cash option to become Medicaid eligible. Case managers should work with OPA eligibility staff to establish the total member responsibility to the facility.

RETAINER DAYS

Providers of this service may be eligible for a retainer payment if authorized by the case management team. Retainers are days on which the member is either in the hospital, nursing facility, or on vacation and the team has authorized the provider to be reimbursed for services in order to keep their placement in the residential setting. If a provider rate includes vacancy savings, retainer days are a duplication of services and may not be paid in addition. Payment for retainer days may not exceed 30 days per service plan year. Refer to HCBS 410.